New York State Department of Health

Bureau of Emergency Medical Services

Verification of EMT Certification

Applicant Must Complete this Section. Please type or neatly print in capital block letters.

Home State EMT ID Number: _____ Date of Birth: ____/____/____
Mo. Day Yr

Name: _____ Social Security Number: _____

Section to be Completed by the current certifying State EMS Office

Certification / Registration Number: _____

Expiration Date of Current Certification: _____ Original Date of Certification: _____
Mo Day Yr Mo Day Yr

Has Applicant refreshed his/her Certification in Your State: Yes: ☐ No: ☐ Give Date: _____
Mo Day Yr

Has this person taken a state written and practical exam to recertify? Yes ☐ No ☐

Was Certification in Your State based on Reciprocity from another State or US Military?
Yes: ☐ No: ☐ If Yes, indicate State or Which Armed Service:

If Yes, has this person completed training requirements or a refresher course since initial reciprocity?

Yes: ☐ No: ☐ If Yes, please indicate Date completed: _____
Mo Day Yr

Level of Certification – Please check highest level certification currently held

☐ Basic EMT course met or exceeded DOT standard
☐ EMT- Intermediate course met or exceeded DOT standard
☐ EMT-Paramedic course met or exceeded DOT standard
☐ Other. Please explain or attach copy of curriculum.

Please indicate modules included in training:
Mast ☐ Defib ☐ IV ☐ ET ☐

Is there any reason that reciprocity should NOT be granted this person?
Yes: ☐ No: ☐
If Yes, please explain on reverse side or include in separate document.

Has this person ever applied for an Accommodation under ADA ? Yes ☐ No ☐

This is to verify that the above individual successfully completed a state administered practical skills examination and written examination and is certified/registered/licensed in your state. The applicant completed the written examination by reading it and marking her/his own answer sheet.

SIGNATURE _____ PRINTED NAME _____
TITLE _____ STATE _____
DATE: _____ TELEPHONE NUMBER: _____

Please insert this original form in the envelope provided. Seal the envelope and sign across the back flap. Mail envelope to applicant at the address provided on the front of the envelope.

New York State Bureau use ONLY

Verification by: Ph Fax Mail Web Log#: _____ Level: B I P Status: Grant Deny

Person Contacted: _____ Title:_____ Send: Card Ref Ltr

Reviewed by: _____ Completed on: _____ Exp Date: _____ EMT#: _____